The Inherent Jurisdiction of the Irish High Court: Interface with Psychiatry

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Abstract

The term "inherent jurisdiction" refers to a set of default powers, usually not set out in statute, which enables a court to fulfil its roles. We discuss recently reported cases where such power has been exercised by the Irish High Court and what this means for psychiatrists in practice. These cases demonstrate that (a) the Irish High Court can be involved in decision-making where there is a lacuna in mental health legislation and a lack of mental capacity; (b) when a minor has been placed by the Court in a specialist facility in the UK and then attains the age of 18 years, decisions can be based on mental capacity but not on preventative detention on the basis of risk; (c) complexities arise when definitions of mental disorder vary between jurisdictions, especially when the Court orders involuntary detention in a case where statute would not ordinarily allow this; and (d) the appropriate route to seek decision-making for adults with mental incapacity is through Ireland's "Ward of Court" process, although, on the face of it, this seems to be contrary to the approach taken in other cases in which inherent jurisdiction was used. Overall, while it is reassuring for state health services that they can seek to approach higher courts in respect of decision-making in complex cases, some of these decisions raise important ethical questions for psychiatrists who may be asked to treat patients detained under their care who may not have a treatable mental illness as their condition falls outside of mental disorder within Irish legislation. We recommend that clear guidance is made available to psychiatrists in light of these judgments, particularly as there is likely to be a reconsideration of cases where Irish patients are placed in the UK given the UK's planned departure from the EU.

Keywords

Ireland, Irish, High Court, Inherent Jurisdiction, Psychiatry, Mental Health

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1. Introduction

Ireland's statutory mental health legislation, the Mental Health Act 2001 is well established. Capacity legislation, the Assisted Decision-Making (Capacity) Act 2015 ("ADMCA 2015") is more recent and its main provisions have yet to be commenced. Whilst the majority of decisions regarding patients who lack capacity are currently made informally without invoking wardship, until this law is commenced, the legal provisions for the care and treatment of those who lack capacity are under wardship procedures, described by some as "archaic".

The current legal test for capacity in Ireland is set out in case law (*Fitzpatrick v. F.K.* (2009)). The test for assessing capacity includes a presumption that an adult patient has capacity, but that presumption can be rebutted. In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether by reason of permanent cognitive impairment, or temporary factors, the test is whether the patient's cognitive ability has been impaired to the extent that he or she does not sufficiently understand the nature, purpose and effect of the proffered treatment and the consequences of accepting or rejecting it in the context of the choices available at the time the decision is made. In setting out this test Laffoy J. made reference to the three stage approach to the patient's decision making process adopted in *Re C. (Adult: refusal of medical treatment)* (1994). The latter test includes comprehension and retention of treatment information by the patient, the belief of the treatment information and the weighing up of the information in arriving at a decision.

The term "inherent jurisdiction" refers to a set of default powers, not set out in statute, which enables a court to fulfil its roles. Inherent jurisdiction interacts with statutory jurisdiction in a complex manner. This was considered by the Supreme Court in *G. McG v. D.V. (No.2)* (2000). Murray C.J. stated as follows:

"*The concept of inherent jurisdiction necessarily depends on a distinction between jurisdiction that is explicitly attributed to the courts by law and those that a court possesses implicitly whether owing to the very nature of its judicial function or its constitutional role in the administration of justice. The interaction between the express jurisdiction of the courts and their inherent jurisdiction will depend in each case according to the scope of the express*

jurisdiction, whether its source is common law, legislative or constitutional and the ambit of the inherent jurisdiction which is being invoked. Inherent jurisdiction by its nature only arises in the absence of the express."

The "inherent jurisdiction" of High Courts in Ireland has been used in rare cases "as a backstop" to make decisions in respect of care and treatment of psychiatric patients. This has been in cases where there are lacunae in statutes governing the issue in question. In practice this would relate to situations where the issue is not governed by wardship procedures or the Mental Health Act 2001.

The source of inherent jurisdiction lies in the Irish Constitution. Article 34.3.1 of the constitution invests the High Court with "full original jurisdiction in and power to determine all matters and questions whether of law or fact, civil or criminal". It is by virtue of this Article that the High Court hears common law actions and derives the authority to declare the rights and liabilities of individuals. The High Court's inherent jurisdiction may be used in varying contexts and across various matters including "*Parens patriae*, Judicial Review, Granting of Bail, Setting Aside of Unsound Judgments, Disciplining of Officers of Court, Punishing for Contempt, Variation of Trusts and Winding up of Companies" (Donnelly, 2009: 133). *Parens patriae* means "parent of the nation". In law, it refers to the jurisdiction of the state to intervene to protect children and incapacitated individuals from abusive or negligent natural parents or legal guardians. This has been used in Ireland alongside European law (Article 56 of the Brussels II Regulation, Council Regulation 2201/2003) to access treatment for minors in a specialist facility in the United Kingdom where no suitable facility exists in the Irish Republic.

The inherent jurisdiction of the courts co-exists with statutory jurisdictions, but the courts must abide by canons of construction. For example, courts must defer to other institutions of government (Donnelly, 2009: 132). Donnelly states that a judge must exercise the court's inherent jurisdiction "with the utmost restraint, ensuring that no judicially created construct operates to supersede a rule of statute." (Donnelly, 2009: 132). Courts have stated that exercise of inherent jurisdiction should only be as a "last resort" (*Health Service Executive v V.E.*, 2012) or a "backstop" when statutes do not govern the situation (*A.M. v Health Service Executive*, 2019: para. 91). In inherent jurisdiction cases, the courts state that they are

upholding various constitutional rights, such as the right to life, the right to protection of the person and the right to bodily integrity. This approach is a "top-down" one, relying on constitutional rights which are superior to legislation (Brady, 2017: 144).

The inherent jurisdiction of the courts exists in other jurisdictions such as England and Wales, Canada, Australia and New Zealand (Ruck Keene, 2013; Hall, 2016; Lacey, 2003; Ferrere, 2013; Joseph, 2005). The courts in England and Wales have used this in cases where vulnerable adults have required protection. Unlike in Ireland, this power has been used by English courts even where an individual does not lack mental capacity, as a safety net, and this was not superseded by England's capacity legislation, the Mental Capacity Act 2005 and its Code of Practice. (*D.L. v A Local Authority and others* [2012] EWCA Civ 253; Ruck Keene, 2013)

We discuss four recent cases reported from Irish courts in respect of patients of mental health services and what they mean for psychiatric practice. The circumstances of each are in the public domain and have been synopsised to highlight aspects relevant to practising psychiatrists. The cases were selected on the basis of recency, availability in the public domain and their potential impact on psychiatric practice. The cases are suitably representative of the current approach of the Irish courts concerning inherent jurisdiction in mental health and capacity law.

2. Recent cases

2.1 Case 1: Placement of a patient with long term needs/addressing a lacuna in mental health legislation

Health Service Executive v V.F. [2014] IEHC 628

The Court was approached by health authorities in respect of a middle-aged patient with Wernicke-Korsakoffs syndrome and lacking decision-making capacity in respect of care and treatment. The patient had been detained under the Mental Health Act 2001 but required transfer to a residential care placement. The High Court made an order directing transfer from an approved centre (a psychiatric ward) to an appropriate care facility (a residential care

unit). Inherent jurisdiction of the court was used for placement at a private residential care facility based on reservations on the presence of "mental disorder" as defined within the Mental Health Act 2001 and an argument that Section 22 of the Mental Health Act could not be used for this purpose. The responsible psychiatrist had concerns whether the diagnosis would be encompassed by the definition of mental disorder which is "*mental illness, severe dementia or significant intellectual disability*". Further it was argued that Section 22 of the Mental Health Act was used more commonly to transfer a patient to a general hospital for medical or surgical treatment and the patient's return to the approved centre following that treatment. Section 22 provides that a clinical director of an approved centre may arrange for the transfer of a patient "for treatment to a hospital or other place and for his or her detention there for that purpose". The duration of the detention in the "hospital or other place" may only be for "so long as is necessary for the purposes of his or her treatment" and the patient must then be taken back to the approved centre from which he or she is transferred. This period of detention is deemed to be detention in the centre from which he or she was transferred. It was argued that Section 22(2) contemplates the return of the patient after treatment to the original approved centre and did not therefore apply to the circumstances of this patient. The Court heard evidence from a number of psychiatrists in respect of the complexities of the patient's presentation and care needs before making an order. The Court sought to strike a balance between the patient's right to personal liberty and the danger posed by her condition to her right to life and personal safety, and the personal safety of others. It formed the view that detention in the placement was the least restrictive way of ensuring the patient's wellbeing, care and safety. McDermott J. stated that this order was "*rare and exceptional*", noting *"the danger is that the same difficulties will arise in respect of applications for long term care in secured therapeutic environments which are unapproved under the Mental Health Act. This will lead to applications to the High Court for further care orders which involve periodic review of the necessity for the continued detention of the patient. The oversight of the care and treatment of persons with mental incapacity on a day to day basis would be better addressed by the appropriate professionals within an improved statutory framework which with its present lacuna gave rise to this problem."*

For psychiatrists, this case means that in exceptional cases, the High Court can be involved in decision making where there is a lacuna in mental health legislation and a lack of

capacity. It clarifies the limitations of section 22 of the Mental Health Act in that it should not be used for long term placement.

2.2 Case 2: Care decisions cannot be determined on the basis of risk alone/Inherent jurisdiction cannot be used to detain an adult with capacity

Health Service Executive v J.B. [2015] IEHC 216
and
Health Service Executive v J.B. (No.2) [2016] IEHC 575

This case was in respect of the care of a young male approaching the age of majority suffering with conduct disorder, personality disorder and bipolar disorder (in remission) placed in England as a minor for therapeutic and educational purposes by Order of the High Court made 3 years previously, pursuant to the inherent jurisdiction of the Court and Article 56 of the Brussels II Regulation. There had been no suitable facility within the Irish republic. The young man had expressed a wish to return to Ireland.

The Court, on hearing evidence from a number of psychiatrists, found a lack of decision-making capacity and authorised the patient's continuing detention in England. It recommended that a committee of doctors be established to oversee the patient's transition to Ireland and to advise on when and how such a transition might be effected.

The following year, in a second judgment, the Court clarified that the primary issue for the Court was whether the patient, now an adult, had capacity to make material decisions as to his residence, care arrangements and his medical treatment in terms of his medical disorder. The Court rejected the view that the patient must continue to be treated in England, despite medical evidence that there would otherwise be a very high risk of relapse as a "preventative detention" approach was not acceptable in terms of the application of mental health law in Ireland. The Court had to consider strongly vindicating the constitutional right as an Irish citizen to reside in this State where possible, pursuant to Article 40 of the Irish Constitution

1937 and the right to family life in the Irish State pursuant to Article 41 of the Irish Constitution 1937.

The Court found that the inherent jurisdiction only applies where there is an absence of a statutory scheme for the detention of the individual involved. The Mental Health Act 2001 regulates the detention and treatment of persons with a mental disorder. However, where a person suffers from a mental impairment which does not come within the scope of the Act, there is no statutory scheme that regulates when therapeutic intervention can be imposed. The Court found, therefore, that it cannot exercise its inherent jurisdiction to circumvent statute and that a person cannot be detained for a personality disorder, as s.8(2)(a) of the Act explicitly prohibits involuntary admission based on personality disorder. The Court found, based on medical evidence, that J.B. had capacity. As an adult with capacity who was not presently detainable under the 2001 Act, any further detention of J.B. would be illegal. O'Hanlon J. noted that while a person may not be detainable under the 2001 Act, that person may still have significant needs and may be considered to have a disability within the meaning of section 2 of the Disability Act 2005 and have a reasonable expectation to have his right to the provision of a safe place of abode vindicated. The Court further held that the Health Service Executive was statutorily obliged to provide secure and settled interim accommodation to J.B. under the Disability Act 2005 pending suitable long-term accommodation being provided by the local County Council.

For psychiatrists, this case is one of many likely to arise as minors have often been placed in a specialist facility in the UK based on inherent jurisdiction and European law where no such facility exists in Ireland. When they reach the age of 18 years, this triggers an evaluation of capacity and ongoing needs. The judgment clarifies that decisions are primarily based on capacity and cannot be based on preventative detention on the basis of risk. It also makes clear that inherent jurisdiction will not be used by courts to circumvent the statutory provisions of the Mental Health Act such as for treatment of personality disorder. It remains to be seen how these cases will be affected by the possible departure of the UK from the European Union. It is not known whether facilities in the EU outside of the UK have been used in similar circumstances.

2.3 Case 3: The Court can order for a patient to be transferred back to Ireland and for their detention in an approved centre.

Health Service Executive v K.W. [2015] IEHC 215

This case related to a young adult who had been placed in a facility in England as a minor due to a lack of a suitable facility in Ireland, who subsequently reached the age of majority. The diagnosis was argued as a type of personality disorder, one which would meet the definition of mental disorder in England, but not in Ireland. There was a significant risk of self-harm. The patient wished to return to Ireland.

The Court was requested to determine whether the patient had capacity to make decisions regarding her future care and treatment and in turn whether it had jurisdiction to detain her further at the UK based facility to protect her personal rights under Article 40 of the Irish Constitution 1937.

The Court, on hearing medical evidence, found that the patient lacked capacity in terms of making material decisions regarding her medical treatment and therapy and in turn her best interests and personal rights under Article 40 of the Irish Constitution 1937 were endangered, necessitating the intervention of the Court. The court relied on previous decisions such as *Health Service Executive v J.O'B.* (2011) where it had been held that courts could use their inherent jurisdiction in such cases.

The Court noted the patient's wish to return to Ireland and directed that her transition to Ireland happen within a three-month time span. The Court, exercising its inherent jurisdiction, ordered that the respondent be involuntarily detained as a psychiatric patient in a named adult psychiatric ward in Ireland, under the care of the clinical director.

For Psychiatrists, this case highlights the complexities where definitions of mental disorder vary between jurisdictions. This is particularly the case for personality disorder which is excluded from the definition of mental disorder within the Mental Health Act in Ireland but not in England and Wales, the neighbouring jurisdiction. It however raises the more problematic issue where a Court orders involuntary detention at an approved centre in a

case where the statutory definition of mental disorder would not ordinarily allow this. It is also unclear why inherent jurisdiction rather than wardship, which is statutory, was used in this case given the medical evidence in respect of lack of capacity.

2.4 Case 4: Inherent jurisdiction should not normally be used where there is mental incapacity as the wardship process is statutory

In Re AM. [2017] IEHC 184
and
A.M. v Health Service Executive [2019] IESC 3

This case relates to an adult with a severe mental illness who lacked mental capacity and related to an application for continued detention at a forensic psychiatric hospital in view of clinical treatment needs. The Mental Health Act could not be used in this case as it would have required the patient's interim transfer to a local psychiatric unit. However, no local unit was willing to accept him due to level of risk posed. The judgment clarified the distinction between "wardship" and "inherent jurisdiction". The additional complexity in this case arose from the fact that individual was also detainable under Mental Health legislation, as suffering from a "mental disorder" within the meaning of the Act.

Wardship jurisdiction is conferred by the Lunacy Regulation (Ireland) Act 1871 and s.9 of the Courts (Supplemental Provisions) Act 1961. The court noted that a number of conditions have to be met before a person can be taken into wardship. The Court must be satisfied that the person is of unsound mind and is incapable of managing his or her own person and affairs. The court must also be satisfied that it is appropriate and necessary to make the person a ward of court in order to protect his or her person and or property. The jurisdiction is discretionary (see *In Re D.* (1987)).

The health service had applied for an order making the patient a ward of court, and the President of the High Court granted the order, determining that the exercise of any inherent jurisdiction was not required in the case of an adult who has mental incapacity. The patient had argued that he would have stronger safeguards of his rights if he were detained under the Mental Health Act. The court stated, in response, that the patient's rights under wardship

would be no less than those of a person detained under the Mental Health Act. The patient was made a ward of court at the forensic psychiatric hospital, with a review ordered for a date three months after the date of the order.

The case was appealed at the Supreme Court (*A.M. v Health Service Executive*, 2019). The issue for determination was whether the HSE or any other person who seeks to have a person involuntarily detained on mental health grounds can do so by way of wardship procedure and by the invocation of the inherent jurisdiction of the High Court, notwithstanding the fact that the appellant satisfies the criteria for a detention order under the Mental Health Act 2001.

The Supreme Court considered whether the President of the High Court had erred in exercising his jurisdiction and making an Order for Wardship. The question arose as to what is "the lawful course of action where a person simultaneously falls within the criteria necessary to be made a Ward of Court, and also come within that category of persons who may be the subject of an involuntarily detention order under the Mental Health Acts." The Court found that no law existed to remove the wardship jurisdiction of the High Court and Circuit Court with regard to persons of "unsound mind". While orders cannot be made simultaneously under both Acts, "mirror procedures" are permissible in order to protect the rights of persons being made wards of court. These procedures include, for example, regular reviews, appointment of a medical visitor to examine the ward of court, and liberty to apply to the court on short notice (para. 100).

The health service had argued that inherent jurisdiction of the courts no longer plays a role in cases such as these. But the Supreme Court confirmed that in other cases, the inherent jurisdiction of the courts will continue to exist as a "backstop" when statutes do not govern the situation (para. 91). The court affirmed the High Court decision to make an order for wardship. The court noted that the provisions of the Mental Health Act 2001 require rethinking to prevent issues like this arising (para. 50).

For psychiatrists, this case signifies that despite evolved statute around mental health, there are exceptional circumstances where the use of the Mental Health Act can be impossible on a practical basis. In such rare cases, it would seem appropriate to approach the courts for

decision making. Even when an individual is detainable under the Mental Health Act, this does not automatically mean that wardship provisions may not apply if there is a lack of capacity. Both cannot be used at the same time. Normally, the appropriate route to seek decision making for adults with mental incapacity is through the wardship process, until the ADMCA 2015 is commenced rather than the court using its inherent jurisdiction. However, in some cases, the inherent jurisdiction may still be invoked.

3. Conclusions

This paper discusses some recently reported Court decisions concerning the care and treatment of psychiatric patients. It is evident that there is a complicated interplay between mental health legislation, capacity legislation and the lacunae that exist despite these. Whilst it is reassuring for state health services that they can seek to approach higher courts in respect of decision making in such complex cases, some of these decisions raise important ethical questions for psychiatrists who be asked to treat patients detained under their care whose condition falls outside of mental disorder within Irish legislation. Whilst case 4 seeks to clarify the difference between the issue of inherent jurisdiction and wardship, in practice this is less than clear and legal precedent seems divergent. It seems that the ward of court system is now being used, where possible, in cases where the person lacks capacity. In 2017, it was stated that "in recent years, the High Court has relied on the inherent jurisdiction to a lesser extent, preferring to use the statutory provisions of the Ward of Court system instead." (National Safeguarding Committee, 2017: 97).

A number of questions arise in respect of the exercise of the inherent jurisdiction in psychiatric cases: does detention under the inherent jurisdiction and subsequent involuntary treatment of mental disorder have sufficient safeguards? Does the inherent jurisdiction have any limitations in scope? We note that the inherent jurisdiction concerning adults with capacity issues continues to exist in England and Wales, and that concerns have been expressed about the lack of clarity and consistency in case-law (Bartlett and Sandland, 2013).

We would recommend that clear guidance is made available to psychiatrists in light of the above judgments, particularly as there is likely to be an impending reconsideration of cases

where Irish patients are placed in the UK under European Law given the UK's planned departure from the EU.

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